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AUTHOR Brown, Thomas G.; Caplan, Thomas; Seraganian, Peter; Werk, Annette

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ABSTRACT

The linkage between conjugal violence and substance abuse is well established. The evidence suggests that little coordination exists among the therapeutic communities positioned to treat co-existing problems. A survey was conducted in Quebec with professionals representing 57 substance abuse treatment centers, 38 of which were public. Questions were asked about their beliefs with respect to conjugal violence; the amount of linkage with conjugal violence intervention milieu; and what obstacles were most important in reducing the level of treatment coordination between the two sectors. Results indicated that little contact occurs between the two milieus and that competition for resources and ideological differences are perceived as important obstacles preventing greater cooperation. More centers engage in direct intervention for female victims than for male perpetrators. A tendency to underestimate the prevalence of concomitant problems and to attribute responsibility for violence onto the woman was noted. These findings are consistent with previous surveys that underscored the segmented approach to these problems and the continued lack of expertise in conjugal violence within substance abuse treatment settings. Innovative strategies are needed to better encourage greater cooperation and integration between treatment communities for co-existing substance abuse and conjugal violence. (Contains 14 references.) (JDM)

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The Response To Conjugal Violence In Substance Abuse Treatment Settings

Thomas G. Brown, Tom Caplan, Annette Werk, Peter Seraganian

Abstract

The linkage between conjugal violence and substance abuse is well established. Not unexpectedly, individuals grappling with conjugal violence problems also present for treatment at clinical substance abuse settings. Strands of evidence suggest that little coordination exists between the therapeutic communities positioned to treat co-existing problems. A survey was conducted with professionals representing fifty-seven substance abuse treatment centers in Quebec (public centers: n = 38). They were queried about their beliefs with respect to conjugal violence, the amount of linkage with the conjugal violence intervention milieu, and what obstacles were most important in reducing the level of treatment coordination between the two sectors. The results indicated little contact occurs between the two milieus, and that competition for resources and ideological differences are perceived as important obstacles preventing greater cooperation. More centers engage in direct intervention for female victims than male perpetrators. Finally, a tendency to underestimate the prevalence of concomitant problems and to attribute responsibility for violence onto the woman was noted. These findings are consistent with previous surveys and reviews that underscored the segmented approach to these problems and the continued lack of expertise in conjugal violence within substance abuse treatment settings. Innovative strategies are needed to better encourage greater cooperation and integration between treatment communities for co-existing substance abuse and conjugal violence.

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The Response To Conjugal Violence In Substance Abuse Treatment Settings

Thomas G. Brown
Douglas Hospital Research Center/McGill University
Pavillon Foster Addiction Rehabilitation Center

Thomas Caplan
Pavillon Foster Addiction Rehabilitation Center
McGill University

Peter Seraganian
Concordia University

Annette Werk
McGill University

The linkage between conjugal violence and substance abuse is well established. Not unexpectedly, individuals grappling with conjugal violence problems also present for treatment at clinical substance abuse settings. Strands of evidence suggest that there is little coordination between the therapeutic communities positioned to treat co-existing problems. In order to determine the attitudes about conjugal violence in addiction treatment settings and the extent of service linkage, professionals representing 57 substance abuse treatment centers in Quebec were queried about their beliefs about conjugal violence, the amount of service linkage, and what obstacles were most important in reducing the level of treatment coordination. The results indicated limited contact between the two milieus, and that competition for resources and ideological differences are perceived as important obstacles preventing greater cooperation. More centers engage in direct intervention for female victims than male perpetrators. Finally, a tendency to underestimate the prevalence of concomitant problems and to attribute responsibility for violence onto the woman was noted. These findings underscore the segmented approach to these frequently co-occurring problems and the continued lack of expertise in conjugal violence within substance abuse treatment settings. Innovative strategies to better encourage greater cooperation and integration between treatment communities for co-existing substance abuse and conjugal violence are discussed.

The association between conjugal and familial violence and psychoactive substance use has been documented in both the research and clinical communities involved in these problem areas. As a general rule, two main features mark this relationship: 1) there is a strong correlation between conjugal violence and the use of alcohol and, in some cases, drugs; 2) intervention is often complicated by the presence of both problems. Given the added risks and huge human and social costs associated with both behaviors individually or together, a concerted strategy for research and intervention is clearly warranted.

Both substance abuse and domestic violence treatment settings are natural entry points for individuals grappling with both substance abuse and violence (i.e., either as a victim of perpetrator) problems (Bennett. & Lawson, 1994; Brown et al., 1998; 1999; Miller, Downs & Gondoli, 1989). Yet, the literature on the conjugal violence-substance abuse linkage is segmented along conceptual (e.g., social, biological, psychiatric), scientific, academic and clinical domains, often with little communication between them. The debate on the intervention strategies for concomitant conjugal violence and substance abuse often has been divisive and ideological. Despite a dearth of comprehensive outcome data, the benefits of both resolution of substance abuse before violence intervention and coordinated treatments for dual-problem individuals are generally acknowledged.

In this context, the results of a recent study that explored the status of coordinated treatment efforts with regards dual-problem men in the state of Illinois are noteworthy. A survey conducted with directors from both treatment milieus sought to clarify the status of coordinated action for the treatment of dual-problem men and women who were both victimized and had substance abuse problems (Bennett & Lawson, 1994). The main findings of their poll were the following: 1) cross-problem screening was haphazard in both milieus, with little recourse to systematic or valid detection and problem characterization; 2) in-house expertise in the cross-problem was often severely limited; 3) while some attempts at linkage with the other treatment settings were found, more effort in consulting the other setting was found among the family violence professionals; 4) when systematic screening was undertaken, referral practices were uneven in both settings. However, violence treatment professionals were more likely than those in substance abuse treatment (95% versus 77%) to refer clients to the other treatment modality.

In order to gain a deeper insight into the situation in Quebec, and to see whether the situation is better here than first reported, a partial replication of the study by Bennett and Lawson (1994) was undertaken. We targeted the attitudes about conjugal violence held by

Thomas G. Brown, Douglas Hospital Research Center/McGill University, Department of Psychiatry, Montreal, Canada. Pavillon Foster Research Unit, St. Philippe de LaPrairie, Qc. Canada.

Tom Caplan, Department of Social Work, McGill University, Montreal Canada; Pavillon Foster Addiction Rehabilitation Center, St. Philippe de LaPrairie, Qc. Canada.

Peter Seraganian, Department of Psychology, Concordia University, Montreal, Canada.

Annette Werk, Department of Social Work, McGill University, Montreal, Canada.

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Correspondence concerning this presentation should be addressed to Thomas G. G. Brown, Douglas Hospital Research Center, Addictions Research Program, 6875 LaSalle Blvd., FBC-1, Verdun, Quebec, Canada

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personnel in substance abuse treatment settings. As well, we queried the respondents concerning the amount of linkage with the other milieu, and what obstacles they felt were significant in reducing the level of treatment coordination.

Method

Questionnaires were mailed along with a cover letter, a consent form explaining the study and procedures, the limits of confidentiality, and a self-addressed prepaid envelope. Once filled out, the questionnaire and signed consent form were to be mailed back to the Douglas Hospital Addiction Research Program. Approximately one month after the initial mailing date all the centers were mailed a reminder card in case they have forgotten to send the questionnaires back, or in case they have not received one at all. This was also an opportunity to send them another copy if the original was misplaced or to encourage them to participate in the study if they had not done so up until that time.

Measurement The questionnaire developed by Bennett and Lawson (1994) for their original survey was utilized. It was adapted so as to be readable by optical character recognition software (Teleform©), technology to automate data seizure from paper-and-pencil questionnaires. After the research team received the hardcopy of the questionnaires, they were scanned to a central computer, which then automatically processed them. Once verified, the results were entered into a database for further analysis.

Results

Respondents Representatives from 57 substance abuse treatment centers mailed back their responses. The province of Quebec is divided into 18 regions. The distribution of responses from the alcohol treatment centers were the following: the Bas Saint-Laurent (10.5%), Quebec (14.0%), Mauricie Bois-Francs (12.3%), Montreal (10.5%), Chaudière-Appalaches (8.8%), Lanaudière (10.5%), and Montérégie (10.5%), regions that reflect both the rural and urban geography of Quebec. Although the questionnaires were addressed to the directors or coordinators of the treatment centers, other personnel often filled them out. The respondents of the substance abuse treatment centers could be divided into the following six job titles: clinicians (including therapists and counselors), 33.3%; coordinators, 10.5%; directors, 42.1%; human relations departments, 5.3%; medical staff, 5.3%; and other, 3.5%. The majority (56.1%) of respondents wereAge & Sex: The majority of respondants of the substance abuse treatment centers wereAge & Sex: The majority of respondants of the substance abuse treatment centers were female.

Attitudes about conjugal violence In response to the statement stating that the fault for male-to-female conjugal violence may be attributed to the male partner, approximately 42% of respondents disagreed. Another statement that proposed that violent men should be held responsible for their abusive behavior because they could have anticipated it elicited 22% disagreement among respondents. When asked whether men are responsible for their conjugal violence because they choose to be violent, approximately 41% disagreed. Finally, 23% disagreed when asked whether the responsibility of conjugal violence rests with the aggressor. In contrast, when asked whether battered women are responsible for their victimization because of their behavior prior to an attack by their partner, 42% felt this was true nearly 50% of the time, while 9% felt it true more than half of the time. Finally, when asked whether the occurrence of conjugal violence resulted from the personality traits of the female victim, 30% agreed.

Extent of concomitant substance abuse and conjugal violence problems in substance abuse treatment
The mode or the most frequently endorsed percentage category to the question concerning the incidence of dual-problem men in substance abuse treatment settings was 10%. In contrast, the mode percentage of women thought to be victimized was mode = 30%.

Extent of Service Linkage Approximately 60% of respondents stated that they sometimes or often use services for battered women. With respect to the utilization of treatments for violent men, the inverse was true with approximately 60% stating that their center rarely or never makes use of these violence programs. Concerning direct contact with personnel from violence treatment settings, 60% of respondents stated that they had little or no contact with their colleagues in the other milieu. Similarly, approximately 9% of respondents indicated that an informal or formal service agreement existed between their service and women's treatment or shelter facilities. In contrast, 88% said they had no formal or informal agreement with the other service.

With respect to services offered to clients in substance abuse treatment, 39% of the respondents said that their centers offered individual counseling for victims, while 21% offered group therapy. For violent men, 19% said they offered group therapy or an educational program, while 23% offered some kind of violence-related individual consultations. The proportion of centers offering individual counseling for the victims was significantly more (χ^2 (1) = 4.73, $p < .05$) than offered the male batterers.

Obstacles to Linkage The most frequently endorsed obstacles to better linkage were competition for resources and funds (i.e., 65%); the qualifications, training and experience of personnel in women's treatment and shelters (i.e., 35%); and the beliefs and attitudes of the personnel in women's programs (i.e., 37%).

Discussion

The major finding from this study is that according to the respondents of the substance abuse treatment facilities polled a systematic and comprehensive approach to conjugal violence and substance abuse in Quebec is lacking. This finding is

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consistent with those of Bennett and Lawson (1994) in their exploration of the status of integration in services targeting substance abuse and conjugal violence problems in Illinois in the early '90's. Similar to this study, the present survey highlighted both conceptual and practical issues that are seen as hampering better coordination. In particular, competition for resources and suspiciousness concerning the professional qualifications and the ideology of the personnel in the conjugal violence network were cited.

Another finding was that there is disagreement concerning the responsibility for violence. Forty percent of the respondents were reluctant to endorse the idea of responsibility being placed upon the male perpetrator. Alternatively, about half of the respondents felt that the responsibility for women's victimization sometimes could be attributed to the woman. Another 30% endorsing the possibility that through their behavior immediately before an aggression or some personality attribute a woman could attract or provoke violence from their partner. These findings suggest that substance abuse treatment personnel often consider mitigating circumstances, such as provocation or a masochistic trait in the female partner, as the rationale for male violence towards women. This is quite different from the prevalent views concerning conjugal violence held in the conjugal violence community, where responsibilizing the male batterer and avoidance of 'blaming the victim' are paramount therapeutic objectives (Stark & Flitcraft, 1991).

Curiously, the proportion of substance abuse professionals who were reluctant to ascribe responsibility for spousal abuse on the violent male substance abuser may be in fact higher than in the general population. Paglia and Room (1998) conducted a poll among over 900 males and females in Ontario exploring their belief and attitudes with respect to the alcohol and aggression relationship. Though more than 75% of the sample believed that alcohol caused aggression, a majority (92%) believed that an intoxicated person is still responsible for any behavior.

The reasons underlying the discrepancy in the attribution of responsibility for violence are speculative. However, it is possible that the dissonance concerning mechanisms underlying conjugal violence between the two settings reflect the lack of specific training in conjugal violence among substance abuse professionals. In addition, it is likely that this conceptual incoherence contributes to the mistrust of the professional qualifications of conjugal violence personnel by the substance abuse milieu.

An additional suggestive finding was the tendency to underestimate the prevalence of concomitant problems in substance abuse treatment setting. Compared to the 10% estimate most frequently endorsed, available data suggest that the prevalence of physically violent men in such settings at approximately 50%. The rate may be much higher if non-physical forms of battering are also considered (Brown et al., 1998). This discrepancy may reflect the lack of a systematic screening protocol in many centers. Moreover, imprecision concerning what constitutes abuse may also contribute to this discrepancy.

The results of the survey also indicated that conjugal interventions are not undertaken in more than half of the centers surveyed, despite the high degree of problem linkage. In addition, of the centers providing direct (individual) services, significantly more provided them to abused women than abusive men. This finding may reflect the controversial view that male battering is symptomatic of substance use problems, and will likely abate if the substance abuse is resolved.

Clinical Implications Both substance abuse and conjugal violence settings are key entry points for dual-problem individuals. Thus, it is likely that when systematic and sensitive screening procedures are not carried out, many cross problems slip by undetected. The dearth of treatment evaluation data prevents us from knowing what impact a persisting cross problem may have for the success of treatment for either conjugal violence or substance abuse. However, in the case of domestic violence, the failure to detect a concomitant and current conjugal violence problem in a substance abuse treatment setting may contribute to the ongoing risk of spouses and family members. Ironically, given the possibility of an inverted U relationship between the severity of substance abuse and the dangerousness of conjugal violence (Leonard & Jacob, 1997; Bennett et al., 1994) there is even reason to believe that a dual-problem man whose substance abuse is resolved may in some cases be a less impaired (and therefore more effective) spouse batterer.

The lack of in-house expertise poses it's own risks. While probing into family violence may be both unfamiliar as well as anxiety producing for many unprepared substance abuse clinicians, it may be seen as of secondary importance to substance abuse counselors. In the case of women undergoing substance abuse treatment, there is evidence that suggests that based upon their substance abuse and reticence to leave an abusive relationship, women may be held responsible for their entrapment in an abusive relationship (Haver, 1987). The present results are consistent with this belief – namely, that blame is often placed on the victim for male violence, either from her behavior or some personality attribute.

Some investigators have proposed different paradigms for the provision of integrated intervention. Effective screening and evaluation may be effective interventions in of themselves. Many substance abusers possessing heavy drinking family and social backgrounds remain unmotivated or fail to seek treatment for their problems due to poor problem recognition. Attempts to refer an individual who has little insight into the severity of his problem are not usually effective. Accordingly, objective and systematic screening, evaluation and feedback has been posited as a means of increasing problem recognition and motivating individuals to initiate conjugal violence treatment as well (Bennett, 1995). Given the pertinence of feedback to motivation in conjugal violence and substance abuse, a motivational approach seems to hold promise for the treatment of both problems (Miller & Rollnick, 1991).

Cognitive behavioral therapies for dual-problems are promising. The advantages include: 1)

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elements of cognitive-behavioral intervention, including stress management, relaxation techniques, communication skills, anger management, and relapse prevention strategies are pertinent to both problems; 2) ideological discrepancies between treatments are avoided; and 3) components of the cognitive-behavioral approach are currently being employed in both treatment settings. In addition, there is support for this approach to linked treatment. For example, men undergoing behavioral couples therapy have been found to both reduce their drinking and the physical abuse of their spouses (O'Farrell et al., 1998). While preliminary, these findings point to the possible benefit of marital therapy for both problems, at least for intact couples.

Collins and colleagues (1997) argue that given the dearth of empirical data about the treatment of both problems within one programmatic context, or the current absence of a coherent paradigm to guide an integrated treatment approach, the most appropriate strategy would be a brokering or case management approach. This might involve one individual overseeing the assessment of all problems, setting treatment priorities, making appropriate referrals, ensuring that referrals are followed, providing a link between different treatment resources, and monitoring treatment outcomes.

As promising as such approaches to integrated treatment appear, it is likely that the individual and organizational change processes will need to be addressed. Change is particularly problematic in substance abuse and conjugal violence treatment settings. In an organizational system where past personal history is often a valued credential in a non-professional intervention agent (Brown, 1995), treatment innovations that diverge from meaningful personal experiences (typically membership in Alcoholics Anonymous; having a history of being victimized) may be viewed with considerable skepticism. While pre-existing or traditional values and belief structures extant in an organization may influence the transfer of an innovation, other contextual factors may also play a role. These include: 1) the rewards or negative consequences of change for the individuals within an organization, 2) perceptions regarding the availability of resources needed to support the innovation, 3) the fears, anxieties and resistance that typically accompany the prospect of change, and 4) the importance of participation of the individuals affected by change in the change process. Given these challenges, both programmers and researchers involved in developing more effective intervention approaches to linked substance abuse and conjugal violence problems might be well advised to integrate principals of organizational readiness to change in their action plans.

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